Davis Health Center
Miller Campus Center 004, SUNY Canton, Canton NY 13617
Phone: 315-386-7333 Fax: 315-386-7932 healthcenter@canton.edu

INFLUENZA IMMUNIZATION CONSENT:

Note: We are unable to vaccinate pregnant women due to the vaccine type available at our clinic.

PLEASE CIRCLE THE APPROPRIATE RESPONSE

Female only: Are you pregnant?	Yes	No
Do you have a history of a serious reaction to a previous influenza vaccine?	Yes	No
Do you have a serious allergy to neomycin?	Yes	No
Do you have a severe allergy to eggs? (Onset of hives after ingesting eggs)	Yes	No
Are you sick with a moderate or severe illness of any kind with a fever over 99 degrees?	Yes	No
Have you ever had Guillain-Barre syndrome?	Yes	No

Note to the Nurse and Patient:

- ☐ Mild side effects include soreness, redness or swelling at the injection site, fatigue, headache, fever, aches and red or itchy eyes. Since the viruses in the influenza vaccine are inactivated, you cannot get the influenza from the vaccine.
- ☐ If Influenza vaccine is administered to immunocompromised individuals including those that receive immunosuppressive therapy, the expected immune response may not be obtained.
- ☐ If you have an adverse reaction to this vaccine, please contact the Student Health Center immediately.
- ☐ The flu vaccine is formulated to prevent seasonal flu and also includes H1N1.

Note to the Nurse: **The nurse may give the vaccine only if the patient answers "No" to the above questions.**

Give all students, faculty or staff 0.5 ml of injectable inactivated influenza vaccine (IIV) IM (22-25g, 1-1½" needle) in the right or left deltoid muscle. A 5/8" needle may be used for adults weighing less than 130 lbs (<60 kg) for injection in the deltoid muscle *only* if the skin is stretched tight, subcutaneous tissue is not bunched, and the injection is made at a 90 degree angle. All people 6 months of age or older should get the flu vaccine. Vaccination is especially important for people at higher risk of severe influenza and their close personnel contacts, including healthcare personnel and close contacts of children younger than 6 months.

COMPLETE VACCINE AFFIRMATION:

I have read the information on both sides of this handout. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of this vaccine and I request that it be administered to me:

Name:	**Address:**
College ID #:	**Date:**
Birth Date: **Age:**	**Patient Signature:**
Mother's Maiden Name: **First** **Last**	

Signature of Nurse:____

Authorization (for LPN): ______________________________________

Name of Vaccine: Afluria Quadrivalent **Manufacturer: Seqirus** **Lot Number: P100110552** **Exp. Date: 5/15/2020**

Date/Time Vaccine Administered:____ Date of VIS: 8/15/2019

Site of Administration: IM L deltoid IM R deltoid

NURSING STAFF ONLY:

- ☐ Check here if you have reviewed the benefits/risks of the vaccine with the patient and given her/him the appropriate V.I.S.
- ☐ Check here if you received a yes answer to any of the following questions and have referred the patient to an MD/NP/PA